

The Law

'No resuscitation' orders — an emerging consensus

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The advances achieved in medical technology over the last several decades have significantly enhanced physicians' abilities not only to improve the quality of medical care but to save and to sustain their patients' lives. For the most part, such benefits from these modern developments have been gratefully received. The ability to resuscitate and prolong an individual's life or, put another way, to exercise greater control over the time and nature of death has, however, given rise to a number of medico-legal issues. Considerable controversy has, in particular, focused upon the propriety and legality of predeterminations or advance orders not to resuscitate patients in certain circumstances. As a consequence of the uncertainties which persisted, the advice to the Canadian Medical Protective Association (CMPA) has consistently been against the writing of 'no resuscitation' orders.

There appears to have been, for some time now, acceptance in the medical profession of the concept that there are conditions of ill health and of impending inevitable death for which resuscitation would be entirely inappropriate. One of the first attempts to establish criteria or to delineate circumstances in which resuscitative measures would be unwarranted happened at a hospital in Great Britain in 1965. The written policy then introduced is said to have included those "who are very elderly (over 65 years of age)" in the category of patients not

to be resuscitated. When this policy statement became public knowledge it resulted in an outcry of national concern. The shock waves from this incident are subsiding only now with the development of much more reliable and valid criteria to be applied in predeterminations about 'no resuscitation'.

Opinions from ethical and religious sources have dealt more with the broad, philosophic or conceptual issues directed more to the first aspect of the question. As a consequence, references from these sources tend to use vague terms such as 'quality of life', 'death with dignity', and 'extraordinary and unusual or heroic means'. Even so, the consensus to be gathered from pronouncements to date is that from both an ethical and a religious perspective, occasions will arise when a physician is not obligated to provide every possible means of artificially prolonging an individual's life.

CMA approved written orders

The Canadian Medical Association, at its annual meeting in 1974, took this one step further and resolved that it is appropriate, medically and ethically, for a physician to write a 'no resuscitation' order for terminal patients whose death seems imminent and inevitable. The Corporation professionnelle des médecins du Québec has also stated in a recent bulletin that a physician in Quebec who acts prudently and who gives sufficient thought to a 'no resuscitation' decision would not be considered to be acting in contravention of the code of ethics enacted for the profession.

A famous American jurist has commented that the law always lags behind the most advanced thinking in every area. Progress in the law must wait until theologians, moral leaders and events have created some common ground, some consensus. This comment is perhaps reflected by the fact that there are no statutes, regulations or court decisions in Canada to date that relate specifically to this whole subject of 'no resuscitation'. There is now emerging, however, even in legal quarters, the beginning of an acceptance of the propriety of 'no resuscitation' decisions and orders.

There are perhaps two inherent legal risks which might face a physician who makes a firm decision in advance not to resuscitate a patient in the event of a sudden cardiac arrest. There is the risk that a family member, perhaps disgruntled with his share of the estate, might institute civil proceedings against the physician alleging medical negligence. More serious, at least in terms of potential consequences, is the risk that the physician may be charged under the Criminal Code of Canada with criminal negligence causing death.

There are, of course, material distinctions to be drawn between a claim for civil negligence and a charge of criminal negligence causing death. Generally speaking, these distinctions relate to a matter of degree. To support a charge of criminal negligence, the extent of the alleged negligence must usually be greater, amounting to wanton and reckless disregard. As well, the onus of proof to be applied in a criminal negligence charge is that of beyond a reasonable doubt,

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rather than on a balance of probabilities. These distinctions aside, however, the essential elements of either a claim for civil negligence or a charge of criminal negligence would be the same. In particular, it must be demonstrated that in exercising his or her duty of care to the patient, the physician failed to meet the standard of care and proficiency required by law and that such failure caused the death of the patient.

Although outside the purview of this article, the causation factor will be one of the main deterrents to any civil claim or criminal charge against a physician. In most situations involving an alleged omission to resuscitate the patient will have been in a moribund state at the material time. It will therefore be difficult to prove that the death of the patient was caused by the omission rather than the underlying state of health of the patient.

In terms of duty and breach of duty, it has long been held through the case law that the general standard of care owed by a physician to a patient is "... that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing . . .". In short, physicians must conform to the standard and recognized practice followed by members of their profession. Physicians charged with negligence, either in civil or in criminal law, can therefore usually clear themselves if they show the court, through medical witnesses and medical testimony, that they acted in accordance with generally approved practice.

Accepting that predeterminations or orders not to resuscitate are to be treated in law as any other medical situation, it follows that physicians should be able to defeat any civil claim or criminal charge of negligence by demonstrating that they acted in conformity with accepted practice. The physician would no doubt be assisted in this defence by the apparent medical, ethical and religious consensus that there are conditions of ill health and impending inevitable death when the technologic capabilities of cardiopulmonary resuscitation

should not be applied. While this line of argument has certain validity as a general proposition, there remains some uncertainty as to the availability of such a defence in any given fact situation.

Each case must, of course, depend upon its own particular facts. It will not be sufficient for physicians merely to point to a general consensus in medical, ethical and religious quarters to defend themselves. They must be able to lead evidence that their medical decisions in the given fact situation conformed with the standard and recognized practice followed by members of their profession. It is very important therefore that the basis of any predetermination not to resuscitate not be, or even be seen to be, an arbitrary one. The reasoning and criteria to be applied by the physician should be sufficiently firm and clear so that should they later be subject to question, any decisions made can be effectively supported. While there need not be unanimity among fellow colleagues, there must be at least a substantial body of opinion in the medical profession that would support both the reasoning and criteria applied and the decision made by the physician in the particular case.

Widely accepted criteria needed

It is in this area, the development of well established and widely accepted criteria to guide a physician in any specific patient situation, that more work needs to be done. The development of necessary framework is already progressing in many hospitals across Canada today. For maximum effectiveness and reliability however, it would be most useful to involve provincial colleges and professional medical associations as well, in completing the task. Regard should also be extended to the well documented and formulated policy statements concerning 'no resuscitation' which are in fairly widespread use in the US today. These policy statements have received increasing recognition and acceptance among jurists and legal commentators in that country over the last short while. In using these American policy statements

as guidelines, allowance must be made for differences in the two jurisdictions, particularly in the decision-making process.

Finally, the rights and interest of patients and their families in the decision-making process leading up to predeterminations or orders not to resuscitate must be considered. A distinction will need to be made here between the competent and incompetent patient.

The law recognizes that every adult of sound mind has a right to determine what shall be done with their own bodies. The right extends not only to the requisite consent of the patient to any proposed course of medical treatment, but as well to the privilege of the patient to refuse available medical treatment. It is equally established in law that no amount of professional skill and good intention can justify substituting the will of the physician for that of the patient. Therefore, even in a situation clearly acceptable from a medical standpoint, the physician has an obligation to discuss the matter with the patient if resuscitation is to be withheld from a terminally ill, but competent and conscious, patient. The physician should explain fully the existing illness and the probable prognosis for the patient with and without resuscitative measures being applied in the event of sudden cardiac arrest. It will then be for the patient to decide whether resuscitative measures should be attempted or not. The patient's family have no say in the matter although often they, too, are part of this decision-making process at the patient's wish.

For years, there has been, and continues to be, a gap in Canadian law with reference to consent on behalf of an incompetent patient to a proposed course of medical treatment, even if clearly needed and remedial. The incompetent patient, whether by reason of mental illness, infirmity or unconsciousness, clearly cannot give consent. There is, as well, no general legal basis for the physician or family members to give consent on behalf of the incompetent patient. While procedures exist for applications to be made to the courts for legal authority to proceed with proposed med-

ical treatment, these procedures may be both time-consuming and costly. It is not surprising therefore that the informal practice has developed for physicians to undertake appropriate medical care of an incompetent patient without valid consent but with the family's approval. Comfort is usually taken in such instances that by obtaining the approval of the family, the most likely source of a potential civil action is eliminated. Further, in the event of a legal action, it is postulated that the courts would be very sympathetic where it is established that the physician acted fairly and reasonably and in the best interest of the patient. However, this informal practice does impose some legal risk for the physician and it follows that the more controversial the medical care, the greater the risk. A proposed 'no resuscitation' order for an incompetent patient might fall into this latter category.

It may be expected that a broadly supported Canadian policy statement concerning 'no resuscitation' orders should help physicians contemplating such an order for an incompetent patient. Certainly the criteria and guidelines so established will serve to reduce the more controversial potential civil and criminal implications of 'no resuscitation' orders generally. As well, such a policy statement may extend to particularize those conditions of ill health and impending death in the incompetent patient for which resuscitation measures would be medically inappropriate and not in the best interest of the patient.

Adopting a Canadian policy statement on 'no resuscitation' will not, however, fully protect the physician from the threat of legal action when applied to an incompetent patient. There will continue to remain the gap in Canadian law relating to the decision-making process. This legal uncertainty can only be resolved through future case law or specific legislation which more clearly defines the responsibility and authority of the physician, the family and the courts in making medical decisions for incompetent patients. Helpful jurisprudence dealing directly with the decision-

making process pertaining to 'no resuscitation' orders for incompetent patients has recently started to emerge in the US. While these American judgements may be of influence, they are not directly applicable or binding in Canada.

Recognizing all the foregoing legal issues, and the uncertainties which have generally prevailed, legal advice to the CMPA has been against the writing in advance of 'no resuscitation' orders. This advice has been predicated only in part by any concern that a civil action or criminal charge might be successful. Regard has also been given to the impact on the physician of even the commencement of such a civil action or criminal charge. Even unsuccessful court proceedings, particularly those with moral or criminal implications, are sometimes seen to be as damaging to a physician's reputation as those which are successful. The advice has therefore been that in appropriate circumstances involving a terminally ill patient, the physician should write informatively in the progress notes about the diagnosis and likely prognosis for the patient. Again, in appropriate circumstances, such notes, properly worded and prominently placed on the patient's chart, should serve as clear indication of the physician's belief that in the event of any sudden cardiac event, resuscitative efforts would not likely be helpful. The ultimate decision to resuscitate or not would remain, however, one of professional judgement to be exercised by the appropriate health care providers caring for the patient contemporaneously with the event itself. This advice would appear to coincide with the current policy on no resuscitation issued by the Veterans Administration in the US, and, as well, conforms generally with the guidelines recommended by the Corporation professionnelle des médecins du Québec.

With the apparent consensus now emerging from all quarters concerning predeterminations or orders not to resuscitate, the advice to the CMPA might now perhaps be qualified to some extent. This may be particularly so with reference to the terminally ill, but competent and

conscious patient for whom resuscitative measures in the event of a sudden cardiac arrest would be entirely inappropriate. Assuming the patient has been given a full explanation of the existing illness and the probable prognosis, with and without attempted resuscitation, and assuming that the patient has exercised his prerogative to refuse future resuscitative measures, the physician should be at little risk either in civil law or criminal law in writing a 'no resuscitation' order. The physician would have additional protection if, with the patient's permission, the family has participated in and concurred with the decision. A broadly supported Canadian policy statement establishing criteria and guidelines for the physician to follow in writing 'no resuscitation' orders would add greatly to the physician's armament.

Unfortunately, there continue to be significant medico-legal issues and therefore associated risks with the writing of 'no resuscitation' orders for incompetent patients. While, once again, a Canadian medical policy statement concerning 'no resuscitation' orders will be helpful to the physician, it will not resolve all of these issues as they relate to the incompetent patient. The decision-making process as it applies to the incompetent patient will remain the important legal stumbling block. The cautionary advice to the CMPA must therefore remain against the writing of 'no resuscitation' orders for incompetent patients. The alternatives for the physician are either to cause an application to be made to the court for authorization to write the order or to rely on the informal practice which has evolved generally with reference to medical care of incompetent patients and seek the approval of the family. The former has practical drawbacks, and may not be successful, and the latter imposes potential legal risks upon the physician. The solution to this dilemma will remain elusive until the legal uncertainty of the responsibility and authority of the physician, the family and the courts in the decision-making process is resolved through future case law or specific legislation. ■